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A Longitudinal Study

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Conflict of interest

The authors declare no conflict of interest.

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Abstract

BACKGROUND: In highly developed countries, childhood overweight as well as many overweight-related risk factors is negatively associated with socioeconomic status (SES).

OBJECTIVE: To investigate the longitudinal association between parental SES and childhood overweight, and to clarify whether familial, psychosocial or behavioural factors can explain any SES gradient.

METHODS: The IDEFICS baseline and follow-up surveys are used to investigate the longitudinal association between socioeconomic status (SES), familial, psychosocial and behavioural factors, and the prevalence of childhood overweight. 5 819 children (50.5 % boys, 49.5 % girls) were included.

RESULTS: The risk for being overweight after two years at follow-up in children that were non-overweight at baseline rises with a lower SES. For children who were initially overweight a lower parental SES carries a lower probability for a non-overweight weight status at follow-up. The effect of parental SES is only moderately attenuated by single familial, psychosocial or behavioural factors; however, it can be fully explained by their concerted effect. Most influential of the investigated risk factors were feeding / eating practices, parental BMI, physical activity behaviour, and proportion of sedentary activity.

CONCLUSION: Prevention strategies for childhood overweight should focus on actual behaviours while acknowledging that these behaviours are more prevalent in lower SES families.

INTRODUCTION

Childhood overweight and obesity is associated with several somatic and psychosocial health-related factors later in life including higher prevalence of comorbidities [1-5], higher mortality rates [5], lower educational attainment [6], and developmental delays [7]. In highly developed countries, childhood overweight and obesity is negatively associated with parental socio-economic status, i.e. overweight and obesity are more prevalent in children from families with low socioeconomic status [8, 9]. This negative SES gradient of childhood obesity indicates SES differences in energy-related behaviours and other psychosocial and familial risk factors, and it is often suggested that, where such a gradient is present, prevention measures should be specifically targeted at low social classes[10]. Parental SES is not directly influencing a child's weight status. A multitude of behavioural factors within the family context has been explored. This is especially true for food-related behaviours[11-13], but also physical activity, sleep, media consumption[14, 15], and, albeit much rarer, psychosocial factors like e.g. lack of social networks have been shown to be associated with childhood obesity[16]. Although familial clustering of overweight and obesity is well established[17], the underlying causes are unknown. They might be driven by genetics, a shared environment, social role modelling, or a combination thereof. Concise research on intermediate factors truly trying to explain the SES-obesity association of childhood obesity is scarce. One of the first attempts is the study of Goisis and colleagues who found that smoking during pregnancy, breastfeeding, early physical activity and dietary factors attenuates the income gradient of childhood overweight and obesity in a UK nationally representative cohort study.[18] However, more studies are needed to substantiate and further investigates these findings.

In a previous study, we analysed the cross-sectional association between socioeconomic status and overweight in the baseline survey of the IDEFICS study, a multi-centre European cohort study on diet- and lifestyle-related diseases in children [19]. We found a negative SES gradient in five of the eight IDEFICS survey centres (Belgium, Germany, Sweden, Estonia, Spain) and a zero association for the other three centres (Cyprus, Hungary, Italy), and we were able to link the presence and direction of the SES gradient to the degree of human development in the survey centres [19]. For the present paper, we will be investigating data of Belgium, Germany, Sweden, Estonia and Spain, since these five centres were shown to be homogenous with regard to their cross-sectional SES-overweight association, allowing pooling of the data.

The aim of the paper is two-fold: Firstly, we would like to investigate the impact of SES at baseline on childhood overweight / obesity at follow-up, and secondly, we would like to clarify whether familial, psychosocial and behavioural factors can explain any observed SES gradient.

METHODS

The IDEFICS study is a multi-centre population-based intervention study on childhood obesity that was carried out in selected regions of eight European countries comprising Belgium, Cyprus, Estonia, Germany, Hungary, Italy, Spain and Sweden [20, 21]. The study was set up in pre- and primary school settings in control and intervention regions in each of these countries. Two major surveys (baseline (T0) and follow-up (T1)) were conducted in pre-schools and primary school classes (1^{st} and 2^{nd} grades at baseline). The baseline survey (September 2007 - May 2008) reached an overall response proportion of 51% (ranging from 41% to 66% in the single countries) and included 16.220 children aged 2 to 9 years. The follow-up survey (September 2009 - May 2010) was conducted two years later, and follow-up was organised such that the schools were visited in the exact same month as they were visited in the baseline survey. The follow-up survey at T1 reached an overall response proportion of 68% (ranging from 49% to 84% in the single countries) and included 11.038 children aged 4 to 11 years. The general design of the IDEFICS study has been described elsewhere [20, 21].

The present study only includes children from the centres in which a social gradient for overweight and obesity was established previously [19] i.e. from Belgium, Germany, Sweden, Estonia and Spain (N=6,497 children), for whom full information on the socioeconomic factors is available. This was the case for 5 819 children (50.5 % boys, 49.5 % girls).

In both surveys, self-administered questionnaires have been filled in by the parents to gather information on the children's behaviours, parental attitudes and on the social environment of the children. The questionnaire was developed in English, translated to the respective languages and back translated to English to minimize any heterogeneity due to translation problems. Different language versions were available in the centres, and help was offered to those parents who felt they were not able to fill in the questionnaire by themselves.

Anthropometric indicators in the children were assessed in the framework of a physical examination. Weight was determined using a TANITA BC 420 SMA with the children being in a fasting status and wearing only underwear. Standing height was measured with the children's head in a Frankfort plane using a stadiometer SECA 225. As in the weight measurement, the children were wearing only underwear, all hair ornaments were removed.

Within both surveys, in random subsamples of participating children additional measurements have been carried out [20]. In the baseline survey, accelerometer measurements are available for 46% of the children. 24 hour dietary recalls have been done in 67.5% of the children. The methodology of these measurements is described below.

Variables included in this study

Familial factors

For assessing the **socioeconomic status (SES)** of the children, we employed an additive SES indicator comprising a) equivalized household income (net income of the household equivalized to the number of household members using the OECD square root scale[22] and adjusted for median equivalized income of the respective country), b) parental educational level (maximum ISCED level of the parents[23]), and c) parental level of occupational position (maximum level of the parents using the European Socioeconomic Classification (ESeC), a modified Erikson-Goldthorpe-Portocarero Schema[24]). Cronbach's alpha for the three indicators was 0.67. We scaled the indicators to the interval [1,5] and summed them up. The SES score ranges from 3 (lowest SES) to 15 (highest SES). The construction of the indicator is described in detail in our previous work [19]. Baseline descriptive data of the SES indicator and its components in the five countries can be found in Supplementary Table A1.

The **familial clustering** of overweight and obesity was assessed using self-reported parental BMI. This was assessed in the questionnaire by the question "What is your height and weight? Please give information of parents with whom the child is living." Any numbers could be given as answers. The parental BMI was calculated as weight (kg) / squared height (m^2).

Parental feeding practices were assessed using an abridged version of the Pre-schooler Feeding Questionnaire (PFQ) developed by Baughcum and colleagues [25]. Items with highest factor loadings were selected relating to the five constructs that were hypothetically related to childhood overweight: *difficulty in child feeding* (it is a struggle to get child to eat, child has poor appetite; Cronbach's alpha 0.79), *concern about child overeating or being overweight* (have to stop child from eating too much, think about putting child on a diet to keep him/her from becoming overweight, worried child is eating too much; Cronbach's alpha 0.82), *pushing the child to eat more* (make child eat all the food on the plate, use food child likes as a way to get child to eat healthy; Cronbach's alpha 0.39), *structure during feeding interaction* (child watches TV at meals (reversed item), parent sits down with child during mealtime; Cronbach's alpha 0.43), and *age-inappropriate feeding* (parent feeds child her-/himself if child does not eat enough).

Psychological factors

Child's strength and difficulties were assessed using the Strength and Difficulties Questionnaire (SDQ) [26]. We assessed four of the five constructs of this questionnaire, namely *emotional difficulties* (Cronbach's alpha 0.63), *behavioural difficulties* (Cronbach's alpha 0.51), *difficulties with peers* (Cronbach's alpha 0.54) and *pro-social behaviour* (Cronbach's alpha 0.58).

Behavioural factors

The assessment of the child's **dietary behaviour** was based on parental report using one computer-assisted 24-hour dietary recall combined with assessment of all school meals of the particular day. Energy intake per day was calculated using country-specific information.

We excluded under- and over-reporters from the data by using adapted Goldberg cut-offs, were Goldberg cutoff values[27] were recalculated for application in children using age- and sex-specific reference values [28]. For our analyses, we adjusted intake by dividing energy intake in calories by body mass in kg. Further details on the 24-hour dietary recall method employed in the IDEFICS study can be found elsewhere[29].

Child's **physical activity** behaviour was assessed by two different methods. In the parental questionnaire, the Outdoor Playtime Checklist (OPC) was employed [30]. From the OPC, we derived the typical outdoor playtime in hours per week of the child. This measure had high rank correlation with accelerometer measurements in a study in pre-school children in the U.S. [30]. Moreover, we asked for the time, the child typically spends in a sports club per week. This questionnaire information was complemented in a subsample of children by accelerometer measurements. The accelerometer device (ActiGraph, Pensacola, FL, USA) was placed on the right hip for three days (two weekdays, one weekend day) during waking hours. The sampling interval (epoch) was set at 15 seconds. Accelerometer measurements were considered to be valid if at least 3-day measurements with a minimum of 6 hours daily wearing time were available. Periods of 20 minutes or more consecutive zero counts were replaced by missing data before further analysis. For the analyses, we used an averaged count per minute, and time spent in moderate or vigorous physical activity using the cut-offs of Evenson [31]. Additionally, the accelerometer data were used to calculate the percentage of time spend in sedentary activities of total accelerometer wear time. Child's **sedentary behaviour** was assessed via parental questionnaire. The hours per week the child typically spends using audio-visual media was assessed for weekdays and weekends separately and averaged over the week. As a second indicator, the number of different media devices in the child's bedroom was assessed using a closed question for the presence of five different types of media devices (TV, Computer, Internet connection, Video / DVD player and PlayStation / Game console).

Statistical methods

Body mass index (BMI) was calculated by dividing body mass in kilograms by squared body height in meters. BMI of children was categorized into International Obesity Task Force (IOTF) categories. For this, we interpolated the given categories for continuous age as proposed by Cole et al. [32, 33] by using cubic splines, and categorized each child according to his / her continuous age (measurement day-birthday) . For this paper, we built two categories for weight status: a) IOTF underweight and IOTF normal weight and b) IOTF overweight and IOTF obese.

To analyse the cross-sectional association of SES on the prevalence of overweight including obesity, age-, and study centre-adjusted prevalence odds ratios (OR) were calculated using logistic regression models.

For longitudinal effects, we analysed the impact of a putative risk factor at T0 on the change of weight status from T0 to T1. For this, hazard ratios (HR) were calculated employing Cox proportional hazard models with age at T1 as time-dependent covariate stratified by weight status at T0. We included the study centres as random effects. Thus, for each weight status we modelled the proportional effects of a factor on the risk of a change of this weight status at any given age independent of study centre. By this approach, we also eliminated country effects and possible intervention / control group effects. Using the same method, we estimated the HR for familial, psychosocial and behavioural factors on a change from IOTF underweight / IOTF normal weight at T0 to IOTF overweight / IOTF obesity at T1. We adjusted the proportional hazard models by SES to explore whether any SES gradients can be explained by the analysed risk factors. In a last step, we analysed the interplay of risk factors on change of weight status in a multivariate model (model I). To ensure that our results were not influenced by the choice of subsamples for accelerometer measurements and / or 24-hour dietary recall, we analysed a second multivariate model where these variable were excluded beforehand (model II). The model building for the two latter models was done using best subset selection to eliminate any possible bias introduced by automated model building procedures [34]. We reported the Wald statistics to judge the relative importance of the single factors[35]. Statistical significances are reported based on a significance level of α=0.05.

All statistical analyses were done with SAS 9.2 (SAS Institute, Cary (NC), USA). The code is available from the authors upon request.

Ethical issues

All parents or legal guardians of the participating children gave written informed consent to data collection, examinations, collection of samples, subsequent analysis and storage of personal data and collected samples. Additionally, each child gave oral consent after being orally informed about the modules by a study nurse immediately before every examination using a simplified text. Study participants and their parents / legal guardians could consent to single components of the study while abstaining from others. All procedures were approved by the relevant local or national ethics committees by each of the five study centres, namely from the Ethics Committee of the University Hospital Ghent (Belgium), the Tallinn Medical Research Ethics Committee of the National Institutes for Health Development (Estonia), the Ethics Committee of the University Bremen (Germany), the

Ethics Committee for Clinical Research of Aragon (Spain), and the Regional Ethical Review Board of Gothenburg (Sweden).

RESULTS

Basic characteristics of the 5,819 included children (2,931 boys, 2,888 girls) can be found in Table 1. The sample is well balanced regarding sex and country (ranging from 17.6% children from Germany to 24.2% children from Sweden). At T0, the prevalence of overweight and obese children was 12.3% (N=712). Two years later, at T1, this prevalence was 15.4% (N=896). The proportion of children with a change of weight status from T0 to T1 was 5.5% for underweight / normal weight at T0 to overweight / obesity at T1 (N=320; 6.3% of all underweight / normal weight children at T0) and 2.4% for a change from overweight / obesity at T0 to underweight / normal weight at T1 (N=140; 19.7% of all overweight / obese children at T0).

>>>> Include Table 1 about here

Table 2 shows the influence of SES on the weight status and on the change of weight status over time. Within the cross-sectional surveys, SES is associated with overweight / obesity at both time points. The higher the socio-economic status, the lower the prevalence of overweight / obesity. The SES gradient is slightly steeper at T1 (POR: 0.903 95%CI: 0.882-0.925) than at T0 (POR: 0.919 95%CI: 0.896-0.944). SES is also protective against a change from underweight / normal weight at T0 to overweight / obesity at T1 (HR: 0.938; 95% CI:

0.905-0.974) and bears a higher chance for a change from overweight / obesity at T0 to underweight / normal weight at T1 (HR: 1.108; 95% CI 1.040-1.180).

>>>> Include Table 2 about here

The impact of single familial, psychosocial and behavioural factors on a change from IOTF underweight / IOTF normal weight at T0 to IOTF overweight / IOTF obesity at T1 and on the SES gradient of this change is displayed in Table 3. Statistically significant factors bearing a higher risk of changing to overweight / obesity are parental BMI (maternal BMI: HR: 1.104; 95% CI: 1.080-1.127; paternal BMI: HR: 1.108; 95% CI: 1.073-1.143), child's difficulties with peers (HR: 1.091; 95% CI: 1.015-1.173), parental concern for overweight or overeating (HR: 1.397; 95% CI: 1.281-1.523), age-inappropriate feeding (HR: 1.107; 95% CI: 1.041-1.178) and percentage of sedentary activity (HR: 1.065; 95% CI: 1.030-1.102). Statistically significant protective against such a weight change are reported difficulties in feeding (HR: 0.899; 95% CI: 0.839-0.962), pushing the child to eat more (HR: 0.917; 95% CI: 0.847-0.994), physical activity as expressed in average accelerometer counts per minute (HR: 0.999; 95% CI: 0.998-1.000), daily MVPA in minutes (HR: 0.980; 95% CI: 0.972-0.987) or time spent in a sports club (HR: 0.805; 95% CI: 0.744-0.871). These results hold also after adjustment by SES, which only explains a small part of the observed single effects (data not shown).

The SES gradient (Raw HR for SES score: 0.938; 95% CI: 0.905-0.974) was most strongly attenuated (change towards the 1) by maternal BMI (Adjusted HR for SES score: 0.960; 95% CI: 0.924-0.998), followed by the physical activity behaviour of the child and the child's strengths and difficulties.

>>>> Include Table 3 about here

The results of the multivariate models are displayed in Table 4. In model I, which contains all investigated variables, three variables are protective to weight status change from T0 to T1. This concerns difficulties in feeding (HR: 0.842; 95% CI: 0.755-0.940) daily MVPA (HR: 0.976; 95% CI: 0.958-0.955) and time spent in a sports club (HR: 0.847; 95% CI: 0.758-0.946). A higher risk for weight status change from T0 to T1 carry parental BMI, age-inappropriate feeding (HR: 1.295; 95% CI: 1.172-1.430) and time spent in sedentary activities (HR: 1.125; 95% CI: 1.018-1.244). The hazard rate for accelerometer average count per minute, which was below 1 in the bivariate model (Table 3), is at 1.006 (95% CI: 1.003-1.009) in the multivariate model.

Similar results were obtained in model II that does not include the variables that are only available in subsamples (accelerometer, 24-hour dietary recall). Here, pro-social behaviour as a further protective factor was included in the model (HR: 0.900; 95% CI: 0.824-0.984). The HRs for SES were closer to unity and no longer statistically significant in both multivariate models (model I: HR for SES: 0.987; 95% CI: 0.930-1.048; model II: HR for SES: 0.997; 95% CI: 0.954-1.023).

>>>> Include Table 4 about here

DISCUSSION

This paper investigated the longitudinal association of familial, psychosocial and behavioural factors with childhood overweight and their interplay with socio-economic status. In our study, a low parental SES in non-overweight children is a risk factor for the development of overweight or obesity two years later. This effect of parental SES is only moderately attenuated by single familial, psychosocial or behavioural factors; however, it can be fully explained by the concerted effect of such factors. Most influential factors for the development of overweight or obesity were feeding / eating practices, parental BMI, the child's physical activity behaviour, and time spent with audio-visual media, which was surprisingly protective in our study. For the child's strengths and difficulties single effects were found which were no longer significant in multivariate models. We also found that, vice versa, for children who were initially overweight a lower parental SES carried a lower probability to change back to a non-overweight weight status. For this case, the effect of most behavioural factors was simply reversed (see supplementary table A3).

The findings from our study confirm the results from the literature regarding the high and independent impact of parental BMI on the risk for overweight of the offspring [36]. Our results regarding the association of parental feeding practices with overweight in children differ from the result obtained in the original study by Baughcum and colleagues [25]. In their cross-sectional study surprisingly only two of the five investigated factors were associated with childhood overweight. In our study, we found a longitudinal effect of four factors on the risk of a non-overweight child to develop overweight or obesity in one of the multivariate models. Two of the investigated factors, pushing the child to eat more as well as difficulties in child feeding, were not risk-elevating factors as hypothesized by Baughcum et al [25], but were protective. However, other longitudinal studies also found overeating to be positively and picky eating to be negatively associated with BMI [38]. Moreover, it is likely that the child's BMI is influencing parental feeding practice, thus confounding any cross-sectional associations [39]. Previous studies have linked children's strengths and difficulties with childhood overweight [40, 41]. However, effects have been found to be rather small. A longitudinal study showed that the effect of weight status on later Strength and Difficulties Questionnaire (SDQ) score might be larger than the effect of SDQ score on weight change [42]. In our study, a higher score on the SDQ subscale peer problems in non-overweight children was statistically significant related to the risk of developing overweight at T1. Previous cross-sectional studies have repeatedly shown associations between objectively measured physical activity with weight status in children [43, 44]. However, the rare longitudinal studies show ambiguous results [45-47], and association might be bidirectional [48]. In our study, both average counts per minute (cpm) and daily MVPA in minutes contributed to the hazard of becoming overweight at T1 in children that were non-overweight at T0, and these variables were also able to explain part of the SES gradient of the overweight risk, albeit the hazard ratio for average cpm was a risk factor in the multivariate model. A possible explanation could be non-linearity in either the MVPA-obesity association or proportion of sedentary activities-obesity association, or even both. We also included questionnaire data on physical activity in our models Time spent in a sports club showed a protective effect in addition to the accelerometer-derived data. This variable was the one with the second highest influence in the model without accelerometer data indicating that this information might be valuable in studies were collection of objective physical activity data is not feasible. We found no effect of time spent outdoors on weight status. The proportion of sedentary activity derived from accelerometer data was a risk factor for obesity in the bivariate as well as the multivariate model. This is very similar to the results of Mitchell and colleagues [49] , however the raw effect (Table 3) does not disappear when adjusted by physical activity and other confounders (Table 4).

The current study has several limitations. First of all, the data of the study stems from a multi-centre intervention study [50] which could have potentially influenced weight status at follow-up. For the sake of statistical power, we decided to include the intervention regions in our study, and we statistically controlled for a possible effect by including study centre as random effect. Secondly, we cannot rule out selection bias due to nonresponse. In the IDEFICS study, we observed selection with regard to weight status at baseline [51]. This should not influence our results, since we restricted ourselves to underweight and normal weight children. A further selection bias can have been introduced within this paper due to the number of missing values, and measurements only performed in sub-samples. This holds especially for the multivariate models presented in Table 4. Although the subsamples were selected randomly, the parents could refuse any single procedure of the surveys. We found only little differences in SES scores of the children included in Model 1 (mean SES score = 10.61) versus Model II (mean SES score = 10.70), compared to a mean SES score of 10.46 in the overall sample.

With the exception of the accelerometer measurements all of the investigated familial, psychosocial and behavioural factors including the social indicators of the study were gathered by parental self-report, which might have influenced the results. Most of the derived variables stem from well-known validated instruments [25, 30, 52-54], however the reliability as measured by Cronbach's alpha for some of the sub-scales is very low. We only included multi-scales that had similar Cronbach's alpha values with our data as those published by the scale authors or by other previous papers. Nevertheless, especially two of the feeding / eating practices (pushing the child to eat more, structure during meals) have extremely low values and should be interpreted with caution. Both sub-scales did not enter the multivariate models. While SES is often used as a putative confounder in validation studies, the validity of self-reported social indicators themselves is largely understudied. The energy intake of the child assessed by 24-hour dietary recall is only derived from a single day of reporting. Although the validity of the instrument in general appears to be high [55], the restriction to a single day of reporting implies that the variable we used, energy intake, is only valid on group level, but not necessarily on individual level [56]. This very well might explain the lack of association between energy intake and risk of overweight in our study.

A particular strength of the study is the fact that the data was gathered in a standardized way in all participating centres. The BMI measurement followed a strictly standardized procedure and was taken with the children being in a fasting status. Children not in fasting status were generally excluded from the database, and we had only 70 (1.2%) documented cases were very small amounts (like e.g. a cookie) had been eaten in the last 8 hours prior to the examination. Quality control procedures, like e.g. central trainings and external site visits, ensured comparability of measurements across centres. Height and weight measurements in the IDEFICS survey centres have an intra- and inter-observer reliability of more than 99% in each of the study centres [57]. Moreover, the questionnaire data on physical activity behaviour is supplemented by objective data from accelerometer measurements in a subsample of children. In a separate validation study, the accelerometer measurements (counts per minutes) in small children show a high correlation with energy expenditure derived by doubly labelled water measurements [58].

Another advantage of our study is the strict longitudinal approach. We are able to disentangle cause and effect and rule out any reverse causation that might otherwise have biased the results.

In our study, the association of SES and childhood overweight was fully explained by familial, psychological and behavioural factors. This result suggests that prevention measures do not inevitably have to target specific social groups. Although, it is true that obesity-prone behaviour is more prevalent in low SES groups and that it takes tailored efforts in terms of communication and measures to be successful in these groups [59, 60], it has to be kept in mind that there is not a one-to-one association between the here investigated factors and SES group. Moreover, specific attention to one group might lead to stigmatization and thus may have unwanted side-effects [61]. An alternative intervention approach would be targeting specific behaviours, e.g. age-inappropriate feeding, in the total population working with a broad choice of culturally sensitive measures through different channels.

CONFLICT OF INTERESTS

We certify that there is no conflict of interest with any financial organisation regarding the material discussed in the manuscript.

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REFERENCES

1. Lobstein T, Jackson-Leach R. Estimated burden of paediatric obesity and co-morbidities in Europe. Part 2. Numbers of children with indicators of obesity-related disease. *International journal of pediatric obesity : IJPO : an official journal of the International Association for the Study of Obesity* 2006; **1**(1)**:** 33-41.

2. Pietrobelli A, Espinoza MC, De Cristofaro P. Childhood obesity: looking into the future. *Angiology* 2008; **59**(2 Suppl)**:** 30S-3S.

3. Park MH, Falconer C, Viner RM, Kinra S. The impact of childhood obesity on morbidity and mortality in adulthood: a systematic review. *Obesity reviews : an*

official journal of the International Association for the Study of Obesity 2012; **13**(11)**:** 985-1000.

4. Kalarchian MA, Marcus MD. Psychiatric comorbidity of childhood obesity. *Int Rev Psychiatry* 2012; **24**(3)**:** 241-6.

5. Reilly JJ, Kelly J. Long-term impact of overweight and obesity in childhood and adolescence on morbidity and premature mortality in adulthood: systematic review. *Int J Obes (Lond)* 2011; **35**(7)**:** 891-8.

6. Karnehed N, Rasmussen F, Hemmingsson T, Tynelius P. Obesity and attained education: cohort study of more than 700,000 Swedish men. *Obesity (Silver Spring)* 2006; **14**(8)**:** 1421-8.

7. Cawley J, Spiess CK. Obesity and skill attainment in early childhood. *Economics and human biology* 2008; **6**(3)**:** 388-97.

8. Shrewsbury V, Wardle J. Socioeconomic status and adiposity in childhood: a systematic review of cross-sectional studies 1990-2005. *Obesity (Silver Spring)* 2008; **16**(2)**:** 275-84.

9. Ness AR, Leary S, Reilly J, Wells J, Tobias J, Clark E *et al.* The social patterning of fat and lean mass in a contemporary cohort of children. *International journal of pediatric obesity : IJPO : an official journal of the International Association for the Study of Obesity* 2006; **1**(1)**:** 59-61.

10. Magnusson MB, Sjoberg A, Kjellgren KI, Lissner L. Childhood obesity and prevention in different socio-economic contexts. *Preventive medicine* 2011; **53**(6)**:** 402-7.

11. Birch LL, Davison KK. Family environmental factors influencing the developing behavioral controls of food intake and childhood overweight. *Pediatric clinics of North America* 2001; **48**(4)**:** 893-907.

12. Loth K, Fulkerson JA, Neumark-Sztainer D. Food-related parenting practices and child and adolescent weight and weight-related behaviors. *Clinical practice* 2014; **11**(2)**:** 207-220.

13. Neumark-Sztainer D, MacLehose R, Loth K, Fulkerson JA, Eisenberg ME, Berge J. What's for dinner? Types of food served at family dinner differ across parent and family characteristics. *Public health nutrition* 2014; **17**(1)**:** 145-55.

14. Wijtzes AI, Bouthoorn SH, Jansen W, Franco OH, Hofman A, Jaddoe VW *et al.* Sedentary behaviors, physical activity behaviors, and body fat in 6-year-old children: the generation R study. *The international journal of behavioral nutrition and physical activity* 2014; **11:** 96.

15. Reilly JJ. Physical activity, sedentary behaviour and energy balance in the preschool child: opportunities for early obesity prevention. *The Proceedings of the Nutrition Society* 2008; **67**(3)**:** 317-25.

16. Stein D, Weinberger-Litman SL, Latzer Y. Psychosocial perspectives and the issue of prevention in childhood obesity. *Frontiers in public health* 2014; **2:** 104.

17. Bammann K, Peplies J, De Henauw S, Hunsberger M, Molnar D, Moreno LA *et al.* Early life course risk factors for childhood obesity: the IDEFICS case-control study. *PloS one* 2014; **9**(2)**:** e86914.

18. Goisis A, Sacker A, Kelly Y. Why are poorer children at higher risk of obesity and overweight? A UK cohort study. *European journal of public health* 2015.

19. Bammann K, Gwozdz W, Lanfer A, Barba G, De Henauw S, Eiben G *et al.* Socioeconomic factors and childhood overweight in Europe: results from the multi-centre IDEFICS study. *Pediatric obesity* 2013; **8**(1)**:** 1-12.

20. Ahrens W, Bammann K, Siani A, Buchecker K, De Henauw S, Iacoviello L *et al.* The IDEFICS cohort: design, characteristics and participation in the baseline survey. *Int J Obes (Lond)* 2011; **35 Suppl 1:** S3-15.

21. Bammann K, Peplies J, Sjöström M, Lissner L, De Henauw S, Galli C *et al.* Assessment of diet. physical activity and biological, social and environmental factors in a multi-centre European project on diet- and lifestyle-related disorders in children (IDEFICS). *J Public Health* 2006; **14**(5)**:** 279-89.

22. Development OOfEC-oa. *Growing unequal? Income distribution and poverty in OECD countries*: Paris, 2008.

23. UNESCO United Nations Educational SaCOIfS. *ISCED 1997. International Standard Classification of Education*: Montreal, 2006.

24. Harrison E, Rose D. *The European Socioeconomic Classification (ESeC). User guide.*, University of Essex: Colchester, 2006.

25. Baughcum AE, Powers SW, Johnson SB, Chamberlin LA, Deeks CM, Jain A *et al.* Maternal feeding practices and beliefs and their relationships to overweight in early childhood. *Journal of developmental and behavioral pediatrics : JDBP* 2001; **22**(6)**:** 391-408.

26. Goodman R. The Strengths and Difficulties Questionnaire: a research note. *Journal of child psychology and psychiatry, and allied disciplines* 1997; **38**(5)**:** 581-6.

27. Goldberg GR, Black AE, Jebb SA, Cole TJ, Murgatroyd PR, Coward WA *et al.* Critical evaluation of energy intake data using fundamental principles of energy physiology: 1. Derivation of cut-off limits to identify under-recording. *European journal of clinical nutrition* 1991; **45**(12)**:** 569-81.

28. Bornhorst C, Huybrechts I, Ahrens W, Eiben G, Michels N, Pala V *et al.* Prevalence and determinants of misreporting among European children in proxy-reported 24 h dietary recalls. *The British journal of nutrition* 2013; **109**(7)**:** 1257-65.

29. Bornhorst C, Bel-Serrat S, Pigeot I, Huybrechts I, Ottavaere C, Sioen I *et al.* Validity of 24-h recalls in (pre-)school aged children: Comparison of proxy-reported energy intakes with measured energy expenditure. *Clin Nutr* 2014; **33**(1)**:** 79-84.

30. Burdette HL, Whitaker RC, Daniels SR. Parental report of outdoor playtime as a measure of physical activity in preschool-aged children. *Archives of pediatrics & adolescent medicine* 2004; **158**(4)**:** 353-7.

31. Evenson KR, Catellier DJ, Gill K, Ondrak KS, McMurray RG. Calibration of two objective measures of physical activity for children. *Journal of sports sciences* 2008; **26**(14)**:** 1557-65.

32. Cole TJ, Bellizzi MC, Flegal KM, Dietz WH. Establishing a standard definition for child overweight and obesity worldwide: international survey. *BMJ* 2000; **320**(7244)**:** 1240-3.

33. Cole TJ, Flegal KM, Nicholls D, Jackson AA. Body mass index cut offs to define thinness in children and adolescents: international survey. *BMJ* 2007; **335**(7612)**:** 194.

34. Greenland S. Modeling and variable selection in epidemiologic analysis. *American journal of public health* 1989; **79**(3)**:** 340-9.

35. Hosmer DW, Lemeshow S. *Applied logistic regression*, Wiley: New York, 1989.

36. Semmler C, Ashcroft J, van Jaarsveld CH, Carnell S, Wardle J. Development of overweight in children in relation to parental weight and socioeconomic status. *Obesity (Silver Spring)* 2009; **17**(4)**:** 814-20.

37. Vollmer RL, Mobley AR. Parenting styles, feeding styles, and their influence on child obesogenic behaviors and body weight. A review. *Appetite* 2013; **71:** 232-41.

38. Dubois L, Farmer A, Girard M, Peterson K, Tatone-Tokuda F. Problem eating behaviors related to social factors and body weight in preschool children: A longitudinal study. *The international journal of behavioral nutrition and physical activity* 2007; **4:** 9.

39. Musher-Eizenman DR, de Lauzon-Guillain B, Holub SC, Leporc E, Charles MA. Child and parent characteristics related to parental feeding practices. A cross-cultural examination in the US and France. *Appetite* 2009; **52**(1)**:** 89-95.

40. Olsen NJ, Pedersen J, Handel MN, Stougaard M, Mortensen EL, Heitmann BL. Child behavioural problems and body size among 2-6 year old children predisposed to overweight. results from the "healthy start" study. *PloS one* 2013; **8**(11)**:** e78974.

41. Sawyer MG, Miller-Lewis L, Guy S, Wake M, Canterford L, Carlin JB. Is there a relationship between overweight and obesity and mental health problems in 4- to 5-year-old Australian children? *Ambulatory pediatrics : the official journal of the Ambulatory Pediatric Association* 2006; **6**(6)**:** 306-11.

42. Sawyer MG, Harchak T, Wake M, Lynch J. Four-year prospective study of BMI and mental health problems in young children. *Pediatrics* 2011; **128**(4)**:** 677-84.

43. Fulton JE, Dai S, Steffen LM, Grunbaum JA, Shah SM, Labarthe DR. Physical activity, energy intake, sedentary behavior, and adiposity in youth. *American journal of preventive medicine* 2009; **37**(1 Suppl)**:** S40-9.

44. Ness AR, Leary SD, Mattocks C, Blair SN, Reilly JJ, Wells J *et al.* Objectively measured physical activity and fat mass in a large cohort of children. *PLoS medicine* 2007; **4**(3)**:** e97.

45. Ekelund U, Luan J, Sherar LB, Esliger DW, Griew P, Cooper A. Moderate to vigorous physical activity and sedentary time and cardiometabolic risk factors in children and adolescents. *JAMA : the journal of the American Medical Association* 2012; **307**(7)**:** 704-12.

46. Carson V, Rinaldi RL, Torrance B, Maximova K, Ball GD, Majumdar SR *et al.* Vigorous physical activity and longitudinal associations with cardiometabolic risk factors in youth. *Int J Obes (Lond)* 2014; **38**(1)**:** 16-21.

47. Riddoch CJ, Leary SD, Ness AR, Blair SN, Deere K, Mattocks C *et al.* Prospective associations between objective measures of physical activity and fat mass in 12-14 year old children: the Avon Longitudinal Study of Parents and Children (ALSPAC). *BMJ* 2009; **339:** b4544.

48. Hjorth P, Davidsen AS, Kilian R, Skrubbeltrang C. A systematic review of controlled interventions to reduce overweight and obesity in people with schizophrenia. *Acta psychiatrica Scandinavica* 2014.

49. Mitchell JA, Mattocks C, Ness AR, Leary SD, Pate RR, Dowda M *et al.* Sedentary behavior and obesity in a large cohort of children. *Obesity (Silver Spring)* 2009; **17**(8)**:** 1596-602.

50. De Henauw S, Verbestel V, Marild S, Barba G, Bammann K, Eiben G *et al.* The IDEFICS community-oriented intervention programme: a new model for childhood obesity prevention in Europe? *Int J Obes (Lond)* 2011; **35 Suppl 1:** S16-23.

51. Hense S, Pohlabeln H, Michels N, Marild S, Lissner L, Kovacs E *et al.* Determinants of Attrition to Follow-Up in a Multicentre Cohort Study in Children. Results from the IDEFICS Study. *Epidemiol Res Int* 2013.

52. Goodman R. Psychometric properties of the strengths and difficulties questionnaire. *Journal of the American Academy of Child and Adolescent Psychiatry* 2001; **40**(11)**:** 1337-45.

53. Jackson C, Henriksen L, Foshee VA. The Authoritative Parenting Index: predicting health risk behaviors among children and adolescents. *Health education & behavior : the official publication of the Society for Public Health Education* 1998; **25**(3)**:** 319-37.

54. Cullen KW, Baranowski T, Rittenberry L, Cosart C, Hebert D, de Moor C. Child-reported family and peer influences on fruit, juice and vegetable consumption: reliability and validity of measures. *Health education research* 2001; **16**(2)**:** 187-200.

55. Bornhorst C, Bel-Serrat S, Pigeot I, Huybrechts I, Ottavaere C, Sioen I *et al*. Validity of 24-h recalls in (pre-)school aged children: Comparison of proxy-reported energy intakes with measured energy expenditure. *Clin Nutr* 2013.

56. Gibson RS. *Principles of Nutritional Assessment*, 2nd edition edn Oxford University Press: Oxford, 2005.

57. Stomfai S, Ahrens W, Bammann K, Kovacs E, Marild S, Michels N *et al*. Intra- and inter-observer reliability in anthropometric measurements in children. *Int J Obes (Lond)* 2011; **35 Suppl 1:** S45-51.

58. Ojiambo R, Konstabel K, Veidebaum T, Reilly J, Verbestel V, Huybrechts I *et al*. Validity of hip-mounted uniaxial accelerometry with heart-rate monitoring vs. triaxial accelerometry in the assessment of free-living energy expenditure in young children: the IDEFICS Validation Study. *J Appl Physiol* 2012; **113**(10)**:** 1530-6.

59. Viswanath K. Public Communications and Its Role in Reducing and Eliminating Health Disparities. In: Disparities IoMUCotRaAotNsSRPaBtRaUEH, G.E. T, F. M, M.B. W (eds). *Examining the Health Disparities Research Plan of the National Institutes of Health: Unfinished Business*. National Academies Press (US): Washington (DC), 2006.

60. Pena MM, Dixon B, Taveras EM. Are you talking to ME? The importance of ethnicity and culture in childhood obesity prevention and management. *Child Obes* 2012; **8**(1)**:** 23-7.

61. Marmot M, Bell R, Goldblatt P. Action on the social determinants of health. *Revue d'epidemiologie et de sante publique* 2013; **61 Suppl 3:** S127-32.